NEW JERSEY STATE HEALTH BENEFITS COBRA APPLICATION — LOCAL/EDUCATIONAL

HC-0072-1199

DIVISION USE ONLY

HEALTH

Rx

Location #

Term (mos)

1. APPLICANT INFORMATION

Social Security Number

Last Name

Title (Jr/Sr/etc)

First Name

MI

Street Address (Include Apartment #)

City

State

Zip Code + 4

Date of Birth (mm/dd/yyyy)

Gender (M/F)

Relationship to Employee

Marital Status (check one)

- Single
- Married
- Divorced
- Widowed

Area Code

Home Telephone Number

2. CHANGE INFORMATION (If applicable)

a. Type

- ☐ Open Enrollment
- ☐ Special Enrollment
- ☐ Status Change (Complete 2b)

b. Moved Out of Coverage
Area (Date of Move) _____

Add Spouse
(Date of Marriage) _____

Date of Birth of Child _____

Adoption/Guardianship of Child (Proof Required)

Date of
Adoption/Guardianship _____

Other (Specify) _____

3. EMPLOYEE INFORMATION (if different from applicant)

Social Security Number

Last Name

First Name

Date of Birth (mm,dd,yyyy)

4. COVERAGE ELECTION - Select the coverage desired and indicate with an **X** in the appropriate box.

TYPE OF COVERAGE	SINGLE	MEMBER & SPOUSE	FAMILY	PARENT & CHILD(REN)
Health: Traditional				
Health: NJ PLUS				
Health: HMO				
State Prescription Drug Program				

DO NOT SEND PAYMENT WITH APPLICATION - YOU WILL BE BILLED BY THE SHBP.

5. HEALTH PROVIDER INFORMATION

Name of HMO Plan

Your NJ PLUS or HMO Doctor ID #

6. SPOUSE AND DEPENDENT INFORMATION — List all dependents you wish enrolled for coverage. Use a separate page for additional dependents.

Spouse: Last Name	First Name	Date of Birth (mm,dd,yy)	Gender	Social Security Number	*Dependent's HMO doctor, Health Center or NJ PLUS doctor ID #	Natural (C) Adopted (A) Foster (F) Stepchild (S)
Dependent(s)						

7. ☐ **SSA DISABILITY EXTENSION** — Check this block if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health plan or become entitled to Medicare after I elect coverage under COBRA. I understand that my coverage under COBRA will be continuous from the date the employer stopped providing it and that I will be required to pay for the amount due for back coverage. I agree to make future payments in a timely fashion. I understand this COBRA coverage will terminate without notice if payment is not made on time.

APPLICANT'S SIGNATURE _____ **DATE** _____

DO NOT SEND PAYMENT WITH APPLICATION - YOU WILL BE BILLED

HC-0072-1199

— COBRA NOTICE —
CONTINUATION OF STATE HEALTH BENEFITS PROGRAM COVERAGE UNDER COBRA
LOCAL/EDUCATIONAL EMPLOYER

This page is to be completed by Employer (Please print or type)

a. To the Family of —

_____

_____

_____

_____

b. SS#: _____

c. Notice Date: _____

d. Employer Name: _____

e. EI #: _____ **f.** EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer drops out of the State Health Benefits Program.

If you are retiring, you may be eligible for lifetime health coverage in the Retired Group of the State Health Benefits Program. Consult your employer or the Division of Pensions and Benefits **PRIOR** to enrolling for health benefits under COBRA.

If you are not eligible for or do not wish to continue on the group plan under COBRA, you may be eligible for a conversion to a private, direct pay plan with your current insurance carrier. Consult your insurance carrier or your employer if you have questions.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The **SHBP** will send you an invoice of premiums that are due for your coverage.

Instructions for completing the application and a rate chart are enclosed with this notice. You should make a copy of this notice and your completed application for your records prior to mailing the originals to the **Division of Pensions and Benefits**. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact our **SHBP Member Hotline** at (609) 777-4355 and leave your name, Social Security number and telephone number and a representative will return your call within two business days.

g. COBRA EVENT: (check one)

- ☐ Retirement
- ☐ Privatization
- ☐ Termination other than Retirement/Privatization
- ☐ Reduction in Hours
- ☐ Leave of Absence
  - — State/Federal Family Leave
  - — Other
- ☐ Death
- ☐ Divorce or Separation
- ☐ Dependent ineligibility — over age 23
- ☐ Dependent ineligibility — marriage
- ☐ Dependent ineligibility — moved out
- ☐ Medicare Entitlement

j. CURRENT COVERAGE TYPE: (Check one)

HEALTH PLAN			NON-CORE PLAN
Traditional	HMO	NJ PLUS	State Prescription Drug
( ) S	( ) S	( ) S	( ) S
( ) M&S	( ) M&S	( ) M&S	( ) M&S
( ) P&C	( ) P&C	( ) P&C	( ) P&C
( ) F	( ) F	( ) F	( ) F

HMO Plan _____

h. DATE OF COBRA EVENT: _____

i. CONTINUATION TERM: _____ months of COBRA eligibility

k. LAST DATE OF COVERAGE (Month/Date/Year):

Health _____ Rx _____

l. EMPLOYER CONTACT AND TELEPHONE #: _____

m. _____

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE

INSTRUCTIONS FOR COMPLETION OF COBRA NOTICE LOCAL EMPLOYER GROUP 92000

COBRA NOTICE — Completed by employer. *Please print or type.*

a. To the Family of — Indicate the employee's full name and current address. Notice must be mailed to meet legal requirements for the notification of dependents, so the address is essential. If the Notice is being sent to a specific dependent, add an attention line with his/her name.

b. Employee's Social Security Number

c. Notice Date — Date COBRA is signed by the Certifying Authority.

d. Employer Name — Provide the name of your organization, *e.g.*, Roselle Township, Totowa Board of Education, etc.

e. Employer Identification Number (EI#)— Provide the EI# assigned to you by the SHBP.

f. Employee Type — Indicate if the employee is a 10 or 12-month employee., *i.e.*, they have a contract of employment covering ten or twelve months per year.

g. COBRA Event — The event that caused the loss of coverage and entitled the employee and/or dependent(s) to continuation of coverage under COBRA. Choose from the following:

1) retirement;
2) privatization;
3) termination other than retirement, *i.e.*, resignation, lay off, firing (other than gross misconduct);
4) reduction in hours;
5) leave of absence;
6) death of employee;
7) divorce or separation;
8) dependent ineligibility — age 23;
9) dependent ineligibility — marriage;
10) dependent ineligibility — moved out of household; or
11) MEDICARE entitlement, *i.e.*, employee seeks MEDICARE as primary insurance.

h. Date of COBRA Event — Date of the event listed in **g** above. This is not the last date of coverage; it is the date of the event above that will cause coverage to end.

i. COBRA Continuation Term — Number of months of eligibility for COBRA coverage. This is generally 18 months for reasons 1 - 5 in **g** above and 36 months for reasons 6 - 11 in **g** above. If the employee has a Social Security Administration approved disability award, he/she is entitled to 29 months of COBRA coverage. A copy of the SSA approval letter must be sent with the COBRA application. Time on leave of absence just before enrollment in COBRA, unless under the federal and/or State Family Leave Act, counts toward the 18-month period and will be subtracted from the 18 months. Time a member spends on federal or State family leave will not count as part of the COBRA eligibility period.

j. Current Coverage — Mark the type and level of coverage held by the employee at the time of the COBRA event. If HMO, list the name and number of the HMO. Only mark the Prescription Drug coverage if your location belongs to the State Prescription Program.

k. Last Date of Coverage — Indicate the last date under the active coverage of the employee for each of the plans listed in **j** above. This date will always be the last day of the month. For COBRA events 1 - 5 in **g** above, use the chart on page 197 of the *Pensions and Benefits Administration Manual* to determine the date. For COBRA events 6, 7, 9, and 10, the last date of coverage is the end of the month in which the event occurred. For event 8, the last date of coverage is December 31 of the year in which the child turned age 23. For COBRA event 11, the last date of coverage is the MEDICARE effective date of coverage.

l. Name of Employer Contact and Phone Number — Name and phone number of individual who should be contacted if there are questions about the COBRA Notice.

m. Signature of Certifying Authority — Signature of individual authorized to certify that information on the COBRA Notice is correct. *No stamped signatures, please.*

Mail to the employee/dependent the COBRA Notice/Application, a COBRA rate chart, and a copy of the instructions on the reverse side of this page. Hand delivery to the employee does not meet the legal requirement to notify family members covered under the group coverage. Keep a copy of the Notice for your files.

CONTACT THE DIVISION OF PENSIONS AND BENEFITS IF YOU HAVE ANY QUESTIONS REGARDING THESE INSTRUCTIONS OR IF YOU NEED ADDITIONAL BLANK COBRA NOTICES OR APPLICATIONS.

INSTRUCTIONS FOR COMPLETION OF COBRA APPLICATION LOCAL EMPLOYER GROUP 92000

Please read the COBRA Notice on the opposite side of the COBRA Application before you begin to complete the application.

COBRA APPLICATION — Completed by applicant. *Please print or type.*

SECTION 1 — APPLICANT INFORMATION

This section must be completed by the applicant for the COBRA coverage, that is, the individual who will be the insured person. Provide all requested information and enter only one number or letter per block. For relationship to the employee, enter self, spouse, or child.

SECTION 2 — CHANGE INFORMATION

This section is to be completed ONLY if you are already enrolled for COBRA coverage and are changing that coverage.

SECTION 3 — EMPLOYEE INFORMATION

This section only has to be completed if the applicant is/was a dependent of the employee. If the employee is the applicant, the section is left blank. *Note:* the employee does not have to continue coverage to allow a dependent to enroll.

SECTION 4 — COVERAGE ELECTION

PLEASE READ THE INSTRUCTIONS ON THE ACCOMPANYING RATE CHART AT THIS TIME. Indicate the coverage that you are electing by marking the appropriate block. You may only select the type of coverage you had as an active employee, e.g., health and/or prescription drug. If you had health coverage you may select any health plan offered.

If eligible, you may select any health plan offered providing you live within the geographic limits covered by the plan you select. Contact your former employer or the health plan to verify their coverage area. The Traditional Plan has no geographic restrictions — it is good anywhere in the world.

If you select an HMO you must enter the name of the HMO in section 5.

You cannot cover dependents under COBRA that you did not cover at the time of the termination of your active benefits. For example, if you had Husband & Wife coverage before termination you may only select Husband & Wife or Single coverage at this time, not Family or Parent-Child coverage. An exception is if the qualifying event increasing your family, e.g. birth, adoption, marriage, was within 60 days of your COBRA election.

SECTION 5 — HEALTH PROVIDER INFORMATION

If you select either NJ PLUS or an HMO, you must enter your doctor's HMO or NJ PLUS ID#.

Note: Failure to provide this information will delay enrollment with the insurance carrier.

SECTION 6 — SPOUSE AND DEPENDENT INFORMATION

If you selected any coverage other than Single, you must enter the dependents you want covered on your plan. If your dependent children are adopted, foster or stepchildren, enter the appropriate code in the block on the far right. Federal law requires that a Social Security Number be provided for all covered dependents. If you selected coverage in an HMO or NJ PLUS, enter each dependent's primary care physician ID number in the appropriate block.

SECTION 7 — SSA DISABILITY EXTENSION

If you have a disability that has been approved by the Social Security Administration, you may be entitled to an extension of your COBRA coverage for up to 29 months. You must attach a copy of the SSA Award letter approving the disability to obtain this benefit.

SECTION 8 — CERTIFICATION AND SIGNATURE

The application must be signed by the applicant and dated. The legal guardian may sign in the case of a minor child. Please read the certification carefully because it will have a direct impact on your continuation of coverage.

UNSIGNED, UNDATED OR INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED TO THE APPLICANT. ADDITIONALLY, THE COBRA NOTICE PROVIDED TO YOU BY THE EMPLOYER MUST BE SUBMITTED WITH THE APPLICATION.